MEDICARE ADVANTAGE PROGRAM PAYMENT SYSTEM

*payment***basics**

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. Under some MA plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and may pay additional premiums for them. Medicare pays plans a capitated rate for the 14 percent of beneficiaries enrolled in MA plans in 2005. These payments amounted to $51 billion in 2005, 17 percent of total Medicare spending.

Available MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and special needs plans (SNPs). For payment purposes, there are two different categories of MA plans: local plans and regional plans. Local plans may be any of the available plan types and may serve one or more counties. Medicare pays them based on their enrollees' counties of residence. Regional plans, however, must be PPOs and must serve all of one of the 26 regions established by the Centers for Medicare & Medicaid Services (CMS) (Figure 1). Each region comprises one or more entire states.

Defining the Medicare Advantage products Medicare buys

Under the MA program, Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. The coverage must include all Medicare Part A and Part B benefits except hospice. All plans, except PFFS plans, must also offer an option that includes the Part D drug benefit. Plans may limit enrollees' choices of providers more narrowly than under the traditional fee-for-service program. Plans may supplement Medicare benefits by reducing cost-sharing requirements, providing coverage of non-Medicare benefits, or providing a rebate of all or part of the Part B or Part D premium. To pay for these additional benefits, plans must use their cost savings in providing the Medicare benefit and may charge a supplemental premium.

Determining Medicare payment for local MA plans

Beginning in 2006, plan bids will partially determine the Medicare payments they receive (Figure 2). Plans will bid to offer coverage to Medicare beneficiaries. CMS will base the Medicare payment for a private plan on the relationship between its bid and benchmark.

The benchmark is a bidding target. Congress set the local MA benchmarks in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) at the county-level payment rates used to pay MA plans before 2006. (Those payment rates were at least as high as per capita FFS Medicare spending in each county and often substantially higher because the Congress set floors to raise the lowest rates to stimulate plan growth in areas where plans historically had not found it profitable to enter.) Generally, the law directs CMS to update the local benchmarks each year by the national growth rate in per capita Medicare spending.

If a plan bid is above the benchmark, then the plan receives a base rate equal to the benchmark and the enrollees will have to pay an additional premium that equals the difference between the bid and the benchmark. If a plan bid falls below the benchmark, the plan receives a base rate equal to its bid plus 75 percent of

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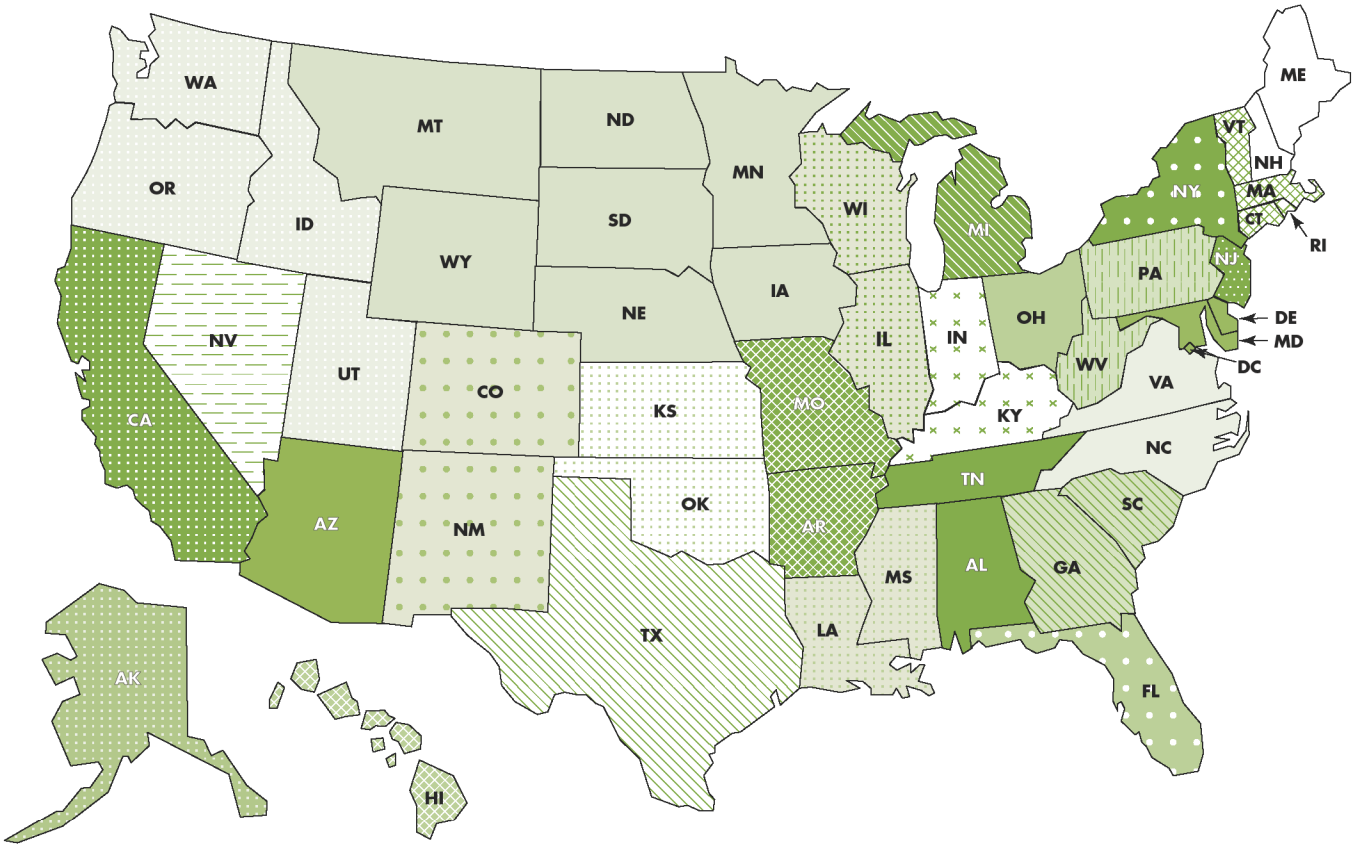
Figure 1 Medicare Advantage regions



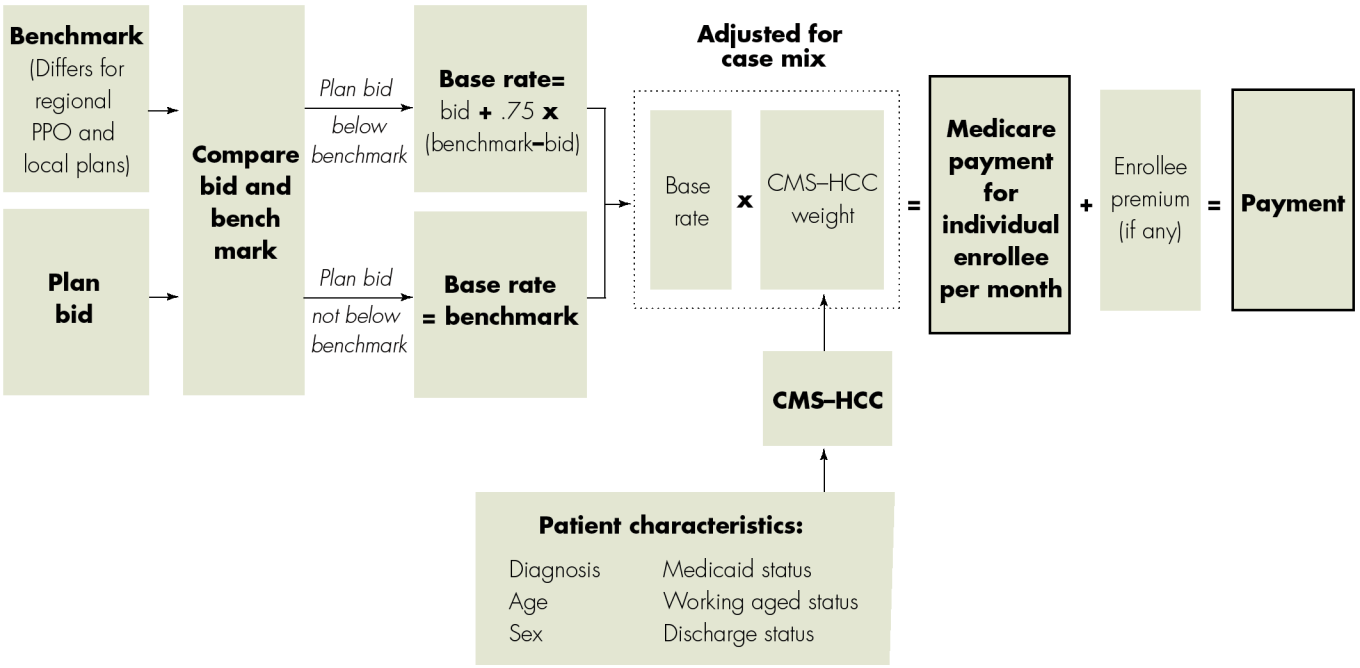
Source: CMS.

the difference between its bid and the local MA benchmark. The MMA defines the difference as "savings." The Medicare program retains 25 percent of the savings, and the plan receives the other 75 percent of the savings as a rebate. The plan must then return the rebate to its enrollees in the form of supplemental benefits or lower premiums. The plan can apply any premium savings to the Part B premium (in which case the government retains the amount for that use), to the Part D premium, or to the premium for the total package that may include supplemental benefits. For example, if a local plan bid $700 per month in a county with an $800 benchmark, the plan would receive a base rate of $775, but would have to provide $75 in the form of reduced premiums or supplemental benefits.

Medicare payments are also based on enrolled beneficiaries' demographics and health risk characteristics. Medicare uses beneficiaries' characteristics, such as age and prior health conditions, and a risk-adjustment model—the CMS–hierarchical condition category (CMS-HCC)—to develop a measure of their expected relative risk for covered Medicare spending. The payment rate for an enrollee is the base rate for the enrollee's county of residence, multiplied by the enrollee's risk measure, also referred to as the CMS–HCC weight.

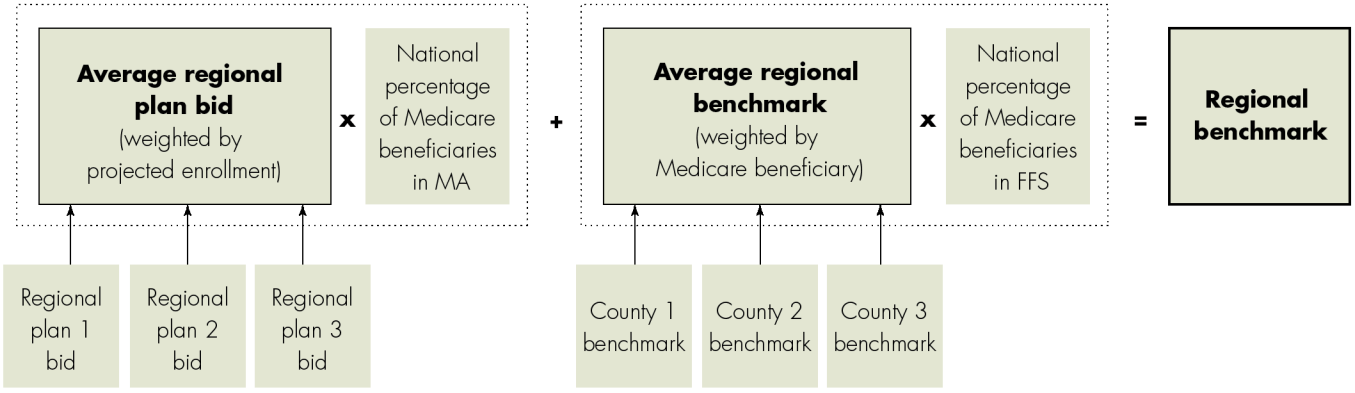
The above system relates to Medicare payments for Part A and Part B services. When a plan offers Part D prescription drug benefits as part of its package, it submits a separate bid for the Part D portion. Payment for the Part D

Figure 2 Medicare Advantage payment system



Note: PPO (preferred provider organization), CMS–HCC (CMS–hierarchical condition category). Medicare payments to regional plans also reflect an intra-service area adjustment.

Figure 3 Setting a benchmark for regional PPOs



Note: MA (Medicare Advantage), FFS (fee-for-service).

prescription drug portion of the plan benefits is calculated separately, the same way as if the plan were offering a stand-alone prescription drug package. The *Part D payment system* document in our "Payment Basics" series provides more information on this topic. The only difference from stand-alone prescription drug plans is that the MA plan may choose to apply some of its rebate payments to lower the Part D premium that enrollees would otherwise be required to pay.

Determining Medicare payment for regional MA plans

Aside from a few special payment incentives[1], payment for regional MA plans is determined like payment for local plans, except that the benchmarks are calculated differently (Figure 3).

CMS determines the benchmarks for the MA regional plans by using a more complicated formula that incorporates the plan bids. A region's benchmark is a weighted average of the average county rate and the average plan bid. As directed by the MMA, CMS computes the average county rate as the individual county rates weighted by the number of Medicare beneficiaries who live in each county. The average plan bid is each plan's bid weighted by each plan's projected number of enrollees. CMS then combines the average county rate and the average bid into an overall average. In calculating the overall average, the average bid is weighted by the number of enrollees in all private plans across the country, and the average county rate is weighted by the number of all Medicare beneficiaries who remain in FFS Medicare. ■

1 The Congress added three types of financial incentives to encourage regional PPOs to participate in MA: risk sharing for 2006 and 2007, a regional stabilization fund, and essential hospital payments that may go to certain hospitals in a regional PPO plan's network. In addition, the MMA established a moratorium on local PPO plan entry in 2006 and 2007 (the act permits existing local PPOs to offer new products within the existing service area). This moratorium is intended to prompt private plans to consider participating as regional PPOs. See pp.65-67 of MedPAC's June 2005 Report to the Congress for more detail.